

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15662

State File No.

FILED MAY 14 1959

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 3312

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u> | | c. CITY OR TOWN <u>ST. LOUIS</u> | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DEACONESS HOSPITAL - (CLINIC)</u> | | e. STREET ADDRESS (If rural, give location) <u>2169 3411 PESTALOZZI ST. 8</u> | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>LOU</u> b. (Middle) <u>G</u> c. (Last) <u>EWERS</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 26 1953</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED: NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u> | 8. DATE OF BIRTH <u>APRIL 29-1884</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u> | 9. AGE (In years last birthday) <u>68</u> If UNDER 1 YEAR: Months Days If UNDER 1 MRS. Hours Min. |
| 11. BIRTHPLACE (City and State or Foreign Country) <u>MONROE COUNTY - IOWA</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13a. FATHER'S NAME <u>GEORGE N EWERS</u> | | 13b. MOTHER'S MAIDEN NAME <u>MARTHA EVANS</u> | |
| 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u>NON RES</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Robert Ewers</u> | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | 19. ADDRESS <u>3411 Pestalozzi</u> | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Shock</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Electric Shock Therapy</u> DUE TO (c) <u>Coronary Sclerosis while under treatment at Deaconess Hosp on March 26 1953</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>asphyx 1130 am 600 Accident</u> | | 20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>Accident</u> | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hosp</u> | |
| 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St Louis Mo</u> | | 21d. HOW DID INJURY OCCUR? <u>E955X</u> | |
| 21e. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Mar 26 53 11:30 am</u> | | 21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>1155A.m.</u> , from the causes and on the date stated above. <u>40</u> | | | |
| 23a. SIGNATURE (Degree or title) <u>Wm. J. Robert</u> | | 23b. ADDRESS <u>1300 Clark</u> | |
| 23c. DATE SIGNED <u>3/28/53</u> | | 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> | |
| 24b. DATE <u>MARCH 28-53</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA CREMATORY</u> | |
| 24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY - MO</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Robert & Co.</u> | |
| 25. ADDRESS <u>1905 So Grand</u> | | DATE REC'D BY LOCAL REG. <u>MAR 28 1953</u> | |
| REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> | | 5P (Licensed Embalmer's Statement on Reverse Side) | |

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No information available.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 14366

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.